MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

★ 1:6838

Reg. Diat. No. 63

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Caroline

City or town: Rural - American Corners

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Rural - American Corners

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John R. Butler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Annie M. Butler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1872

8. AGE: Years	Months	Days	If less than one day
72	7		..... hrs. ..... min.

9. Birthplace: Preston (Caroline) Maryland

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Peter Wesley Butler

13. Birthplace: Caroline County, Md.

MOTHER 14. Maiden name: Martha Blades

15. Birthplace: Caroline County, Md.

16. Informant: H. A. Butler

Address: Federalsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27, 1945 (month) (day) (year)

Cemetery or crematory: Grove Cemetery

Location: Grove, Md.

18. Funeral director: H. M. Hollis

Address: Preston, Md.

19. July 26 1945 (Date rec'd by registrar) C. D. Plummer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1945 to July 25 1945

and that I last saw h.....alive on July 14 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	6 wks
Due to Arteriosclerosis & Hypertension	years
Due to Chronic Myocarditis	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. D. Plummer M.D. M. D. or other

Address: Preston, Maryland Date signed: 7/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

06839

Reg. Dist. No. 6 V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Deulan Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 15 Zeons

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Greenbox Rd. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) If VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Pusey Cope

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6 (b) Name of husband or ~~wife~~ Samuel Cope

6(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1873

8. AGE: Years	Months	Days	If less than one day
72	6	20	hrs. min.

9. Birthplace Harney - Brook Pa
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Henry Pusey

13. Birthplace Penn.

MOTHER 14. Maiden name Emma Myers

15. Birthplace Penn.

16. Informant Samuel Cope

Address Rd. Greenbox - Md.

17. Buried Date thereof 7 - 22 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Deulan Cemetery

Location Deulan Md.

18. Funeral director J. Virgil Mavis

Address Deulan Md.

19. 7-21 1945 Thos D. George
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

	DURATION
Immediate cause of death	
Due to Cardiac Insufficiency	Sudden
Due to Chronic [illegible] Disease	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas D George M. D. or other

Address Union Mills Md. Date signed 7/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

06840

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Kate Downs.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed.

6.(b) Name of husband or wife: William Downs.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 85 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Delmore. (Town, county, and state)

10. Usual occupation: Retired Housewife

11. Industry or business

FATHER
12. Name: John David
13. Birthplace: Del.

MOTHER
14. Maiden name: No Record.
15. Birthplace: No Record.

16. Informant: W. A. Torbert
Address: Dover Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3. 1945 (month) (day) (year)
Cemetery or crematory: Lakeside
Location: Dover Del.

18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.

19. July 2 1945 (Date rec'd by registrar) L. MacPuppin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1944, to June 28 1945
and that I last saw h.. alive on June 28 1945

Immediate cause of death: Pulmonary Tuberculosis

	DURATION
Due to:	6 M.
Due to:	
Other conditions: Arteriosclerosis Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Clark M. D. Greensboro Md. M. D. or other
Address: Greensboro Md. Date signed July 4 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06841

Reg. Dist. No. 64

1. PLACE OF DEATH:
County: Caroline
City or town: Federalsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: Bridgeville Hospital
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: James W. Moore

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	married

6.(b) Name of husband or wife: Clara Moore

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 27, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	22	hrs. min.

9. Birthplace: Maysel, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER
12. Name: Washington Moore
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Boulden
15. Birthplace: Md.

16. Informant: Mrs. Clara Moore
Address: Federalsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Federalsburg, Md.

18. Funeral director: Harvey Williamson
Address: Federalsburg, Md.

19. July 21, 1945 (Date rec'd by registrar) J. J. Farris, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 10 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1945, to July 19, 1945 and that I last saw h... alive on July 19, 1945

Immediate cause of death	DURATION
Left Sided Hemiplegia	1 hour.
Cerebral Hemorrhage	
Due to Arteriosclerosis	P
Due to Hypertension	P
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 7/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191)

CERTIFICATE OF DEATH

06842

★ Reg. Dist. No. 62

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Caroline

City or town: Near Denton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Oliver Nichols

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 14th 1871

8. AGE: Years: 74 | Months: 4 | Days: 21 | If less than one day: hrs. min.

8. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Farmer Laborer

11. Industry or business:

MOTHER FATHER

12. Name: not known

13. Birthplace: —

MOTHER

14. Maiden name: Sarah Willoughby

15. Birthplace: Kentucky

18. Informant: Mrs. Arthur Scott

Address: R.D. Denton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-7-45 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton, Md.

18. Funeral director: J. Virgil Emerson & Son

Address: Denton, Md.

19. 7/7 (Date rec'd by registrar) 1945 Mrs. A. Gent (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to: Cardiac Dilatation	Unknown
Due to: Heart Stroke	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

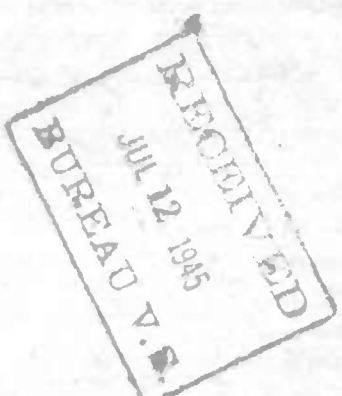
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dawson D. Temple M. D. or other

Address: Denton Date signed: 7/7/45


RECEIVED
JUL 12 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6843

Reg. Dist. No. 64

1. PLACE OF DEATH:
County: Carolin
City or town: Federalsburg, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
R.F.D.
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Clarence Jay Passwaters

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	white	single

B.(b) Name of husband or wife: none
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1945

8. AGE: Years — Months — Days 1 — If less than one day: 3 hrs. min.

9. Birthplace: Federalsburg R.F.D.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: "

FATHER
12. Name: Clarence J. Passwaters
13. Birthplace: Greenwood, Del.

MOTHER
14. Maiden name: Vida Passwaters
15. Birthplace: Rodgersville, Penn.

16. Informant: Mrs. C. J. Passwaters
Address: Federalsburg, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 12, 1945 (month) (day) (year)
Cemetery or crematory: Bloomery
Location: Bloomery, Md.

18. Funeral director: J. H. Williamson
Address: Federalsburg, Md.

19. July 12 1945 (Date rec'd by registrar)
J. J. Garris Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Delivered child 19 at 1:30 P.M. 19
and that I last saw h... July 10 - 45 19

Immediate cause of death	DURATION
(a) Premature birth at 6½ months,	
Due to (b) Mother fell on injuring child,	
Due to (c) before it was born.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible]
M. D. or other
Address: Hurlock, Md. Date signed July 10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

U6844

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:
County Caroline
City or town Federalsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 hr.
Hospital, institution, or street address where death occurred: R.F.D.
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Caroline Md. County
City or town near Preston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Richard James Passwater

3. (b) Social Security Number no

4. Sex M
5. Color or race white
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife none
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 10, 1945
8. AGE: Years — Months 6½ Days — If less than one day 18 hrs. ... min.
9. Birthplace Federalsburg R.F.D. (Town, county, and state)
10. Usual occupation none
11. Industry or business "
FATHER 12. Name Clarence J. Passwater
13. Birthplace Greenwood, Del.
MOTHER 14. Maiden name Tilda Passwater
15. Birthplace Rodgersville, Tenn.
16. Informant Mrs. C. J. Passwater
Address Federalsburg, Md.
17. Burial Date thereof July 12, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Bloomery Cem.
Location Bloomery, Md.
18. Funeral director J. H. Williams
Address Federalsburg, Md.
19. July 12 1945 J. J. Garris Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945, at 8 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Delivered him July 10 1945
and that I last saw h... alive on July 10 1945
Immediate cause of death Premature birth 6½ months — DURATION
Due to Premature birth due to a fall of mother before delivery
Due to
Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations —
— Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE [illegible signature] M. D. or other
Address Hurlock, Md. Date signed 7/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (692)

CERTIFICATE OF DEATH ★

66845

Reg. Diat. No. 63

1. PLACE OF DEATH:
County: Caroline
City or town: Smithson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Smithson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Fannie Babor Prager

3.(b) Social Security Number
219-05-8852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Adolph Prager
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 22, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	24	..... hrs. ..... min.

9. Birthplace: Vienna, Austria
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Paul Babor
13. Birthplace: Austria
MOTHER 14. Maiden name: Marie Turfhan
15. Birthplace: Austria
16. Informant: Gustav Prager
Address: Preston, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1945 (month) (day) (year)
Cemetery or crematory: Jr. Order U; A. M.
Location: Preston, Md.
18. Funeral director: W. H. Hollis & Son
Address: Preston, Md.
19. July 19 19 45 (Date rec'd by registrar) C. W. Plummer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1945 19 ..... at 7:00A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 23 19 45 to July 16 19 45
and that I last saw her alive on July 14 19 .....

Immediate cause of death	DURATION
Hemiplegia	3 days
Due to Arteriosclerosis	50
Due to Chronic Myocarditis	7
Other conditions Toxic Hyperthyroidism ? Osteoarthritis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Earle B. Plummer M. D. or other
Address: Preston, Md. Date signed 7/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21st)

CERTIFICATE OF DEATH

06846

★ Reg. Dist. No. 62

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Caroline
City or town Denton 2nd
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Caroline
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) If VETERAN, NAME WAR

3. (a) FULL NAME Elsie Ivey Satterfield

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	Col.	married

B (b) Name of ~~husband~~ or wife Edgar Satterfield
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4th 1900

8. AGE:

Years	Months	Days	If less than one day
45	6	21	hrs. min.

9. Birthplace Whitelung, Del.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name George T. Calmes
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Bennett
15. Birthplace Del.
16. Informant Louise Boston
Address Denton Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-25-45 (month) (day) (year)
Cemetery or crematory St. Mary's Grove Cem.
Location Denton, Md.
18. Funeral director J. Virgil Master
Address Denton, Md.
19. July 25 1945 M. D. George
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to July 22 1945, and that I last saw h alive on July 22 1945.

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions Uremic Nephritis Heart Decompensation (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Queen Anne Md Date signed 7-31-1945